



**CONSENT AND AUTHORIZATION LETTER
FOR RELEASE PATIENT INFORMATION**

From Patient/ Parent/ Legal Guardian:

Full Name :

NRIC Number :

Phone Number :

Relationship : **Father/ Mother** to patient
(Patient's Name)

hereby expressly authorized **AVISENA HEALTHCARE** to release my information record for application purpose as well as any information pertaining to diagnosis and/or treatment given and/or received at

AVISENA HEALTHCARE Hospital *(Please tick either one);*

AVISENA SPECIALIST HOSPITAL

AVISENA WOMEN'S & CHILDREN'S SPECIALIST HOSPITAL

to my representative as per detail below,

REPRESENTATIVE DETAIL:

Full Name :

NRIC Number :

Relationship : Phone Number:

INFORMED CONSENT STATEMENT

I have read and understood the Personal data protection Notice and I hereby given my consent to AVISENA to process my personal data for the purposes stated in the Personal Data Protection Notice. I also warrant that have sought the consent of any third party whose personal data I have disclosed to AVISENA I also do hereby consent and permit AVISENA to issue the medical report and relinquish AVISENA Specialist Hospital and its healthcare providers from any legal action related to it.

Signature of Patient/ Parent/ Legal Guardian

Date